St. Louis Smile Center

# NEW PATIENT INFORMATION RECORD

TODAY'S DATE _____ / _____ / _____ PATIENT'S BIRTH DATE _____ / _____ / _____

## PATIENT INFORMATION

☐ **Male** ☐ **Female**

**Title:** ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr.

**Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Patient's Name _____
*(Last)* *(First)* *(Middle)*

***If patient is a minor,***
Parent or Guardian's Name _____ Relationship _____

## RESPONSIBLE PARTY #1 INFORMATION

**Title:** ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr.

☐ **Male** ☐ **Female** **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Name _____
*(Last)* *(First)* *(Middle)*

Address _____

City _____ ST _____ Zip Code _____ - _____

Home Phone # (_____) _____ Cell Phone # (_____) _____ Pager # (_____) _____

E-Mail Address (Home) _____ (Work) _____

Previous Address *(if less than one year at above address)* _____

Social Security Number _____ - _____ - _____ Occupation _____

Employer _____ Employee # _____ Working Hours _____

Employer's Complete Address _____

Responsible Party #1 Birth Date _____ / _____ / _____ Work Phone # (_____) _____

Dental Insurance Company _____ ☐Primary ☐Secondary

Insurance Company Address _____

Insurance ID # _____ Control # _____ Group # _____

## RESPONSIBLE PARTY #2 INFORMATION

**Title:** ☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr.

☐ **Male** ☐ **Female** **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Name _____
*(Last)* *(First)* *(Middle)*

Address _____

City _____ ST _____ Zip Code _____ - _____

Home Phone # (_____) _____ Cell Phone # (_____) _____ Pager # (_____) _____

E-Mail Address (Home) _____ (Work) _____

Previous Address *(if less than one year at above address)* _____

Social Security Number _____ - _____ - _____ Occupation _____

Employer _____ Employee # _____ Working Hours _____

Employer's Complete Address _____

Responsible Party #2 Birth Date _____ / _____ / _____ Work Phone # (_____) _____

Dental Insurance Company _____ ☐Primary ☐Secondary

Insurance Company Address _____

Insurance ID # _____ Control # _____ Group # _____

ST. LOUIS SMILE CENTER
Derek J. Vadnal, D.M.D.
11520 St. Charles Rock Road – Suite 205 Bridgeton, MO 63044 (314)298-7772 www.smilestlouis.com drvadnal@smilestlouis.com

***TO OUR PATIENTS:***
***IT IS IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL AND DENTAL HISTORY. THESE FACTS HAVE A DEFINITE BEARING ON YOUR DENTAL HEALTH AND TREATMENT. THIS INFORMTION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR PERMISSION. THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.***

| MEDICAL HISTORY | YES | NO |
|---|---|---|
| Do you have any current HEALTH PROBLEMS? If YES, describe here. | | |
| Are you currently under a PHYSICIAN'S CARE? If YES, list your doctor's name, address, and phone number? | | |
| Have you been hospitalized within the past five years? If YES, what was the reason? | | |
| Do you SMOKE or use other TOBACCO PRODUCTS? If YES, what type and how much? | | |

What is your current HEIGHT and WEIGHT? Height: Weight:

Check all of the following which you have had, or presently have:

___ A.I.D.S. / A.R.C. / HIV Positive
___ Alcoholism
___ Allergies or Hives
___ Anemia
___ Anesthetic Complications
___ Angina Pectoris
___ Anorexia or Bulimia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joints (Hip, Knee, etc.)
___ Asthma
___ Blood Disease (Any)
___ Blood Transfusions
___ Breathing Problems
___ Bruise Easily
___ Chemotherapy (Cancer, Leukemia)
___ Congenital Heart Failure
___ Cortisone Medicine
___ Cosmetic Surgery
___ Diabetes
___ Dysrhythmias
___ Ear Pain
___ Emphysema
___ Epilepsy or Seizures
___ Fainting History
___ Fever Blisters
___ Glaucoma
___ Headaches
___ Heart Attack or Heart Disease
___ Heart Murmur
___ Heart Pacemaker
___ Hemophilia (Bleeding Problems)
___ Hepatitis A (Infectious)
___ Hepatitis B (Serum)
___ High Blood Pressure
___ Intestinal Disease
___ Kidney Trouble
___ Liver Disease
___ Low Blood Pressure
___ Myocardial Infarction
___ Mitral Valve Prolapse
___ Nervousness
___ Pain in the Jaw Joints
___ Psychiatric Treatment
___ Radiation Treatment
___ Renal Disease
___ Rheumatic Fever
___ Stroke
___ Sinus Trouble
___ Stomach Disease
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Venereal Disease (Any)
___ Yellow Jaundice
___ OTHER (Please List)
_____
_____

Are you **ALLERGIC** or have you **REACTED ADVERSELY** to any of the following:

___ Aspirin
___ Codeine
___ Erythromycin
___ Latex
___ Local Anesthesia
___ Nitrous Oxide
___ Penicillin
___ OTHER _____

List any **MEDICATIONS or DRUGS** you are currently taking:

**FOR WOMEN ONLY**

Are you **PREGNANT** at the present time?
___ YES ___ NO

If **YES**, approximately what **DATE** is your baby due?

_____
(Enter Date)

Are you currently taking **ORAL CONTRACEPTIVES**?
___ YES ___ NO

***EMERGENCY INFORMATION: IN THE EVENT OF AN EMERGENCY, WHOM WOULD YOU LIKE FOR US TO CONTACT?***

_____ **EMERGENCY CONTACT NAME**
_____ **RELATIONSHIP**
(_____) **AREA CODE**
_____ **PHONE NUMBER**

| DENTAL HISTORY | Yes | No |
|---|---|---|
| Do you wear **DENTURES**? If **YES**, which type? ☐ **Full** ☐ **Partial** | | |
| Would you like to know more about **PERMANENT REPLACEMENTS** for missing teeth? | | |
| Do your gums ever **BLEED** or feel **TENDER** or **IRRITATED**? | | |
| Have you had any type of **PERIODONTAL (GUM)** treatments? | | |
| Do you use **DENTAL FLOSS** on a **REGULAR** basis? | | |
| Are you aware of **GRINDING** or **CLINCHING** your teeth? | | |
| Do you suffer from **CHRONIC HEADACHES**? | | |
| Does your jaw make **CLICKING** or **POPPING** sounds when you chew or move your jaw? | | |
| Do you have **PAIN** in or around your ears when you chew or move your jaw? | | |
| Have you experienced any **GROWTHS** or **SORE SPOTS** in your mouth? | | |
| If there was a simple and inexpensive way to **WHITEN** your teeth, would you be interested? | | |
| Would you like to change anything about your **SMILE**? If **YES**, what? | | |

Indicate at the right if your teeth are **SENSITIVE** to any of the following:

COLD?

HEAT?

PRESSURE?

SWEETS?

Please enter the Name, Address, and Phone Number (including Area Code) of your **PREVIOUS DENTIST**.

What was the date of your last **COMPLETE** dental examination?

What was the date of your last **FULL MOUTH X-RAYS**?

Is there any other **MEDICAL** or **DENTAL** information that you feel I should know about? If **YES**, please explain.

**PATIENT or GUARDIAN CONSENT**

The undersigned hereby authorizes Dr. Derek J. Vadnal to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of my dental needs. I also authorize Dr. Vadnal to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Vadnal and that I am fully responsible for all dental fees. These fees are due and payable by me at the time services are rendered unless prior financial arrangements have been made and authorized. I also assign all insurance benefits to Dr. Derek J. Vadnal at the St. Louis Smile Center. Any payments received by Dr. Vadnal from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

_____ _____

Patient or Guardian Signature Date

# FINANCIAL ALLIANCE

St. Louis Smile Center
Derek J. Vadnal, D.M.D., L.L.C.

We at St. Louis Smile Center are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible.

We submit dental insurance for you, but **we do require estimated patient portion at time of service**. Treatment fees are only estimates; valid 30 days from date printed and are subject to revision. Treatment could be altered if your dental needs change. Insurance estimates are estimates only!

Please acknowledge that all treatment options for your dental condition have been fully explained. **It is your responsibility to complete treatment and follow recommended maintenance schedules. If treatments and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health and insurance coverage. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints will be based on the fees at the time of service, not those on the original treatment plan.**

We are happy to offer you various payment options: **cash, check, money orders and Visa/MasterCard/Discover/American Express**. In addition we work with several financial companies that, if you qualify, offer you low or no interest loans. We collect your information, submit via internet, you qualify and know the results before you leave our office.

Please understand that you are responsible for the entire balance and for complying with the terms of this office. Your portion of payments are due on (or prior to) services as outlined by our financial coordinator. You also understand that any balance over 60 day past due will be your responsibility and that you may be liable for any attorney fees incurred in collecting the delinquent balance.

We appreciate the trust and confidence you have placed in us for your care.

_____ _____

Sign Date

# HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). **I UNDERSTAND THAT BY SIGNING THIS CONSENT I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT**:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices,** which contains a more complete description of the uses and disclosures of my protected health information, and my rights under the HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time, However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

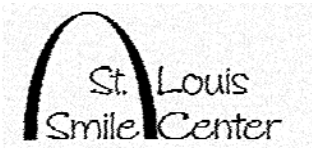
Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

**ST LOUIS SMILE CENTER**
**DEREK J. VADNAL, DMD, LLC**
**11520 ST CHARLES ROCK ROAD, SUITE 205**
**BRIDGETON, MO 63044**

St. Louis Smile Center




## PATIENT or GUARDIAN CONSENT

The undersigned hereby authorizes Dr. Derek J. Vadnal to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of my dental needs. I also authorize Dr. Vadnal to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Dr. Vadnal and that I am fully responsible for all dental fees. These fees are due and payable by me at the time services are rendered unless prior financial arrangements have been made and authorized. I also assign all insurance benefits to Dr. Derek J. Vadnal at the St. Louis Smile Center. Any payments received by Dr. Vadnal from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

_____ _____

Patient or Guardian Signature Date

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